VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (month/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3. American Indian 4. Asian 5. Hispanic 6. Other			10. Provider Name & Address
8. Medicaid I.D. # Previous # if applicable			

11. Enter number of reason recipient is no longer requiring service: _____ **Date Closed**: _____

1. Pregnancy ended
2. Dropped out of prenatal care
3. Transfer to other MICC agency
4. Lost to follow-up
5. Eligibility cancelled
6. Problem resolved
7. Died
8. Moved
9. Other (Specify):

12.. Pregnancy Outcome:
Instructions: Enter pregnancy outcome number only if the answer to item 11 is "1 - PREGNANCY ENDED"

1. Live birth
2. Spontaneous abortion
3. Therapeutic abortion
4. Elective abortion
5. Fetal death
6. Other:

13. Infant's Live Birth Data
Instruction: Complete item 13 only if answer to item 12 is "1 - LIVE BIRTH"

	INFANT #1	**INFANT # 2**
Birth Weight lbs. and ozs.		
Birth Date		
APGAR Score 1 min.		
5 min.		

14. Weeks of gestation at time of birth _____

15. Infant Risk Screen

	Yes	No
a. Has Physician completed risk screen?		
b. If yes, was the infant classified as " high risk"?		
c. If yes, has the infant been referred to Care Coordination		
d. If yes, was the infant born with morbidity?		

16. Infant receiving EPSDT services _____ _____

17. Is the infant receiving WIC services**?**
Yes _____ No _____

18. Enter # of weeks of gestation when mother began prenatal Care: _____

19. Total # of prenatal visits by mother during this pregnancy: _____

20. Did mother receive WIC during Pregnancy?
Yes _____ No _____

21. Did mother receive postpartum or family planning exam?
Yes _____ No _____

22. Client Needs
Instructions: Indicate needs that were met through Care Coordinator assistance by entering "1" in appropriate space(s). Indicate client needs that were not met at the completion of Care Coordination by entering "2" in appropriate space(s).

1. Child Care _____
2. Food Stamps _____
3. Housing _____
4. Nutrition Serv. _____
5. Homemaker Serv. _____
6. Home Health Serv. _____
7. Employment _____
8. School Enrollment _____
9. Psychological _____
10. Job Training _____
11. Transportation _____
12. Substance Abuse Treatment _____
13. Smoking Cessation _____
14. Glucose Monitoring _____
15. Parenting/Childbirth _____

23. Substance abuse at time of delivery
Instructions: Item 23 must be completed if substance abuse was indicated on the Care Coordination Record (DMAS-50)

	# Days/ Week	# Times/ Day		# Days/ Week	# Times/ Day
Alcohol			Amphetamines/Diet Pills		
Cocaine/Crack			Inhalants/Glue		
Narcotics/Heroin			Tobacco/Cigarettes		
Marijuana/Hashish			Other (Specify)		
Sedatives/Tranquilizers			_____		

Coordinator's Signature _____ Date _____